Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Division regarding a medical fee dispute between the requestor and the respondent named above. This dispute was received on 12/23/03.

I. DISPUTE

Whether there should be reimbursement for HCPCS code A4646 ___ for date of service 8/28/03.

II. RATIONALE

The service in dispute was denied as, "TR17-Billed procedure code is not accepted by TWCC."

Commission Rule 134.202 (b), Medical Fee Guideline, effective 8/1/03, states that, "For coding, billing, reporting, and reimbursement of professional medical services, Texas Workers Compensation system participants shall apply the Medicare program reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies in effect on the date a services is provided with any additions or exceptions in this section." To determine the maximum allowable reimbursement (MAR) for professional services system participants shall apply the Medicare payment policies with the following minimal modifications: Rule 134.202 (c) (2) states, "For Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L: (A) 125% of the fee listed for the code in the Medical Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule."

The Requestor states, in their letter dated 11/19/03, "The contrast charge, HCPCS code A4646 (supply of low osmolor contrast material) was denied. According to the insurance department at TWCC, HCPCS code A4646 is a separately billable charge and is eligible for reimbursement."

The Carrier completed the bottom portion of the TWCC 60 that was received by the Commission on 1/8/04, however, provided no relevant information pertaining to their denial rationale.

The Medicare Carrier Manual, Section 15022 Payment Conditions For Radiology Services (F), states in part, "Low Osmolar Contrast Media (LOCM) (HCPCS Codes A4644-A4646)- Payment Criteria- Make separate payments for LOCM in the case of all medically necessary nonhospital patients. In the case of intraarterial and intravenous radiologic procedures, pay separately for LOCM only when it is used for patients with one or more of the following characteristics: A history of previous adverse reaction to contrast material, with the exception of a sensation of heat, flushing, or a single episode of nausea or vomiting; A history of asthma or allergy; Significant cardiac dysfunction including recent or imminent cardiac decompensation, severe arrhythmia, unstable angina pectoris, recent myocardial infarction, and pulmonary hypertension; Generalized severe debilitation; or Sickle cell disease. If the patient does not meet any of these criteria, the payment for contrast media is considered to be bundled." There was no supporting documentation that any of the above characteristics were applicable to the injured worker.

III. DECISION

Based upon the review of the disputed healthcare services within this request, the Division has determined that the requestor is not entitled to reimbursement.

The above Findings and Decision are hereby issued this 31st day of March 2004.

Terri Chance
Medical Dispute Resolution Officer
Medical Review Division

TC/tc